Alabama Medicaid
2018 Budget Hearing

January 30, 2017

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COMMISSIONER
ALABAMA MEDICAID AGENCY

AGENDA

- Overview
- 2018 Budget
- Managing Medicaid
- RCOs
- Federal Healthcare Reform

Who Does Alabama Medicaid Serve?

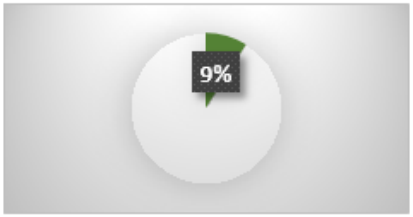
FY2015 by Date of Service

Aged

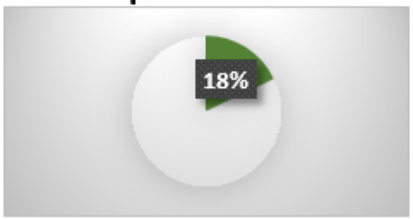
Age 65 & Over

Adults who are in poverty. Almost all are also covered by Medicare.

% of Members



% of Expenditures



$10,297
Per Member Per Year

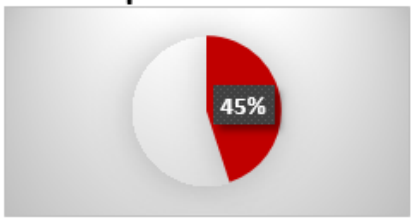
Disabled & Blind

Any Age

Determined by the Social Security Administration and have automatic Medicaid eligibility.

% of Members

% of Expenditures



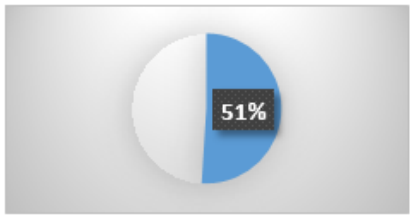
$10,278
Per Member Per Year

Children

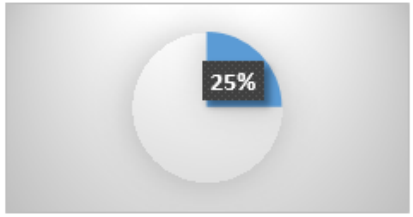
Age 0-18

Children in families below 146% of the Federal Poverty Rate.

% of Members



% of Expenditures



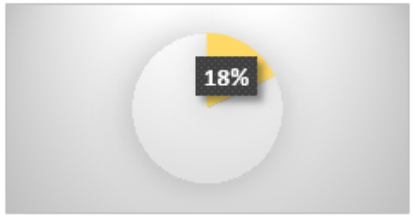
$2,483
Per Member Per Year

Other Categories

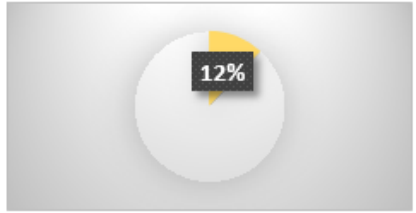
Age 19-64

Other adults including pregnant women, parent caretakers, and family planning services.

% of Members

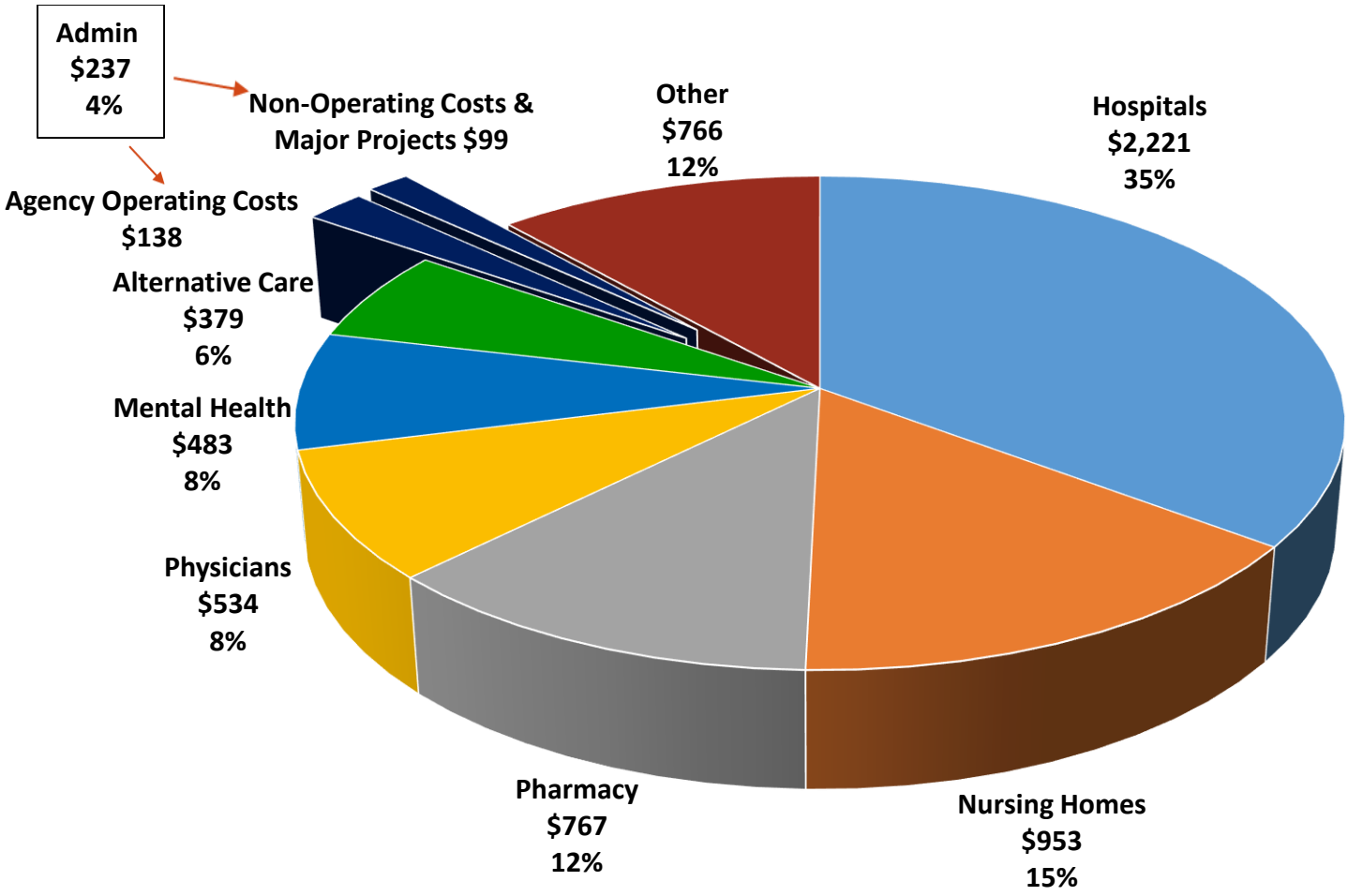


% of Expenditures



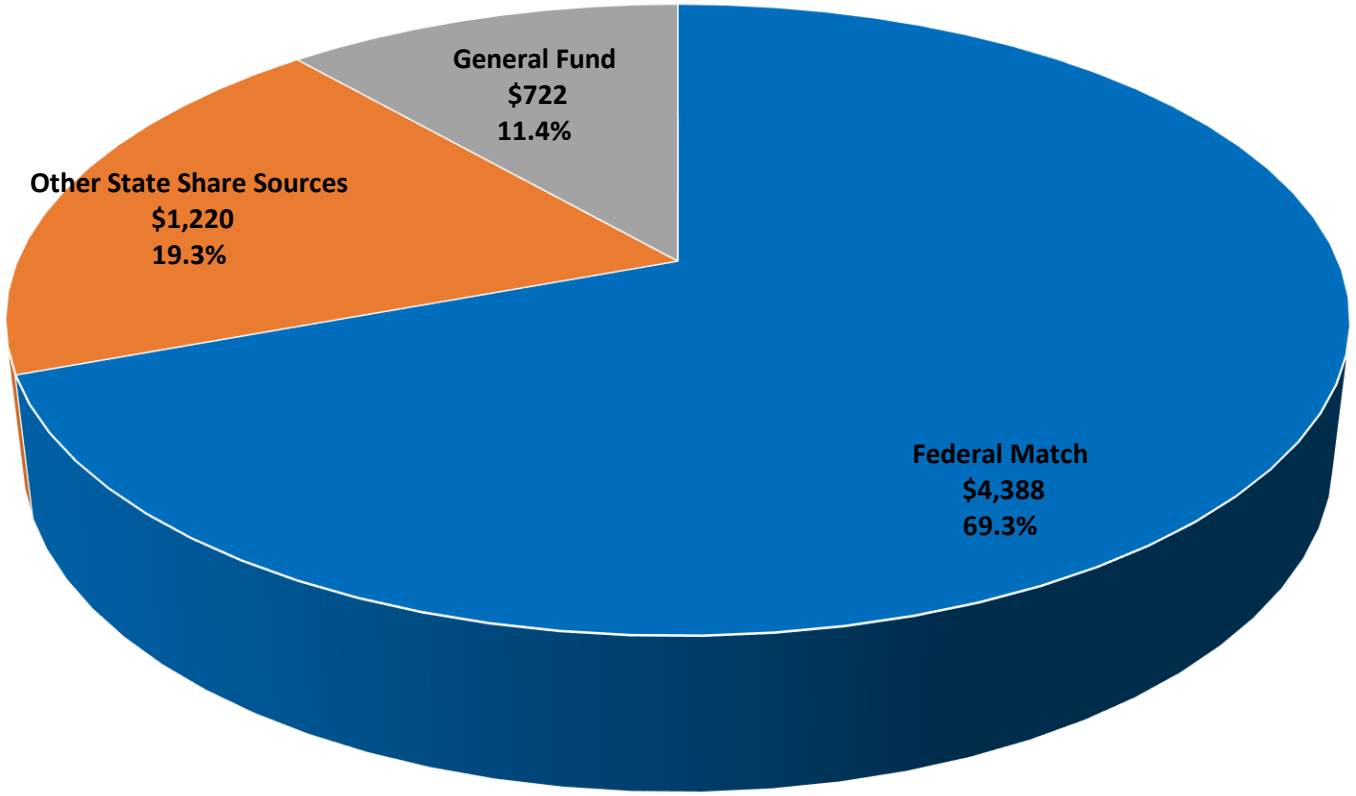
$3,350
Per Member Per Year

FY 2016 Medicaid Expenditure Analysis
Benefit Payments and Administrative Costs (in millions)



Total Expenditures
$6.3 Billion

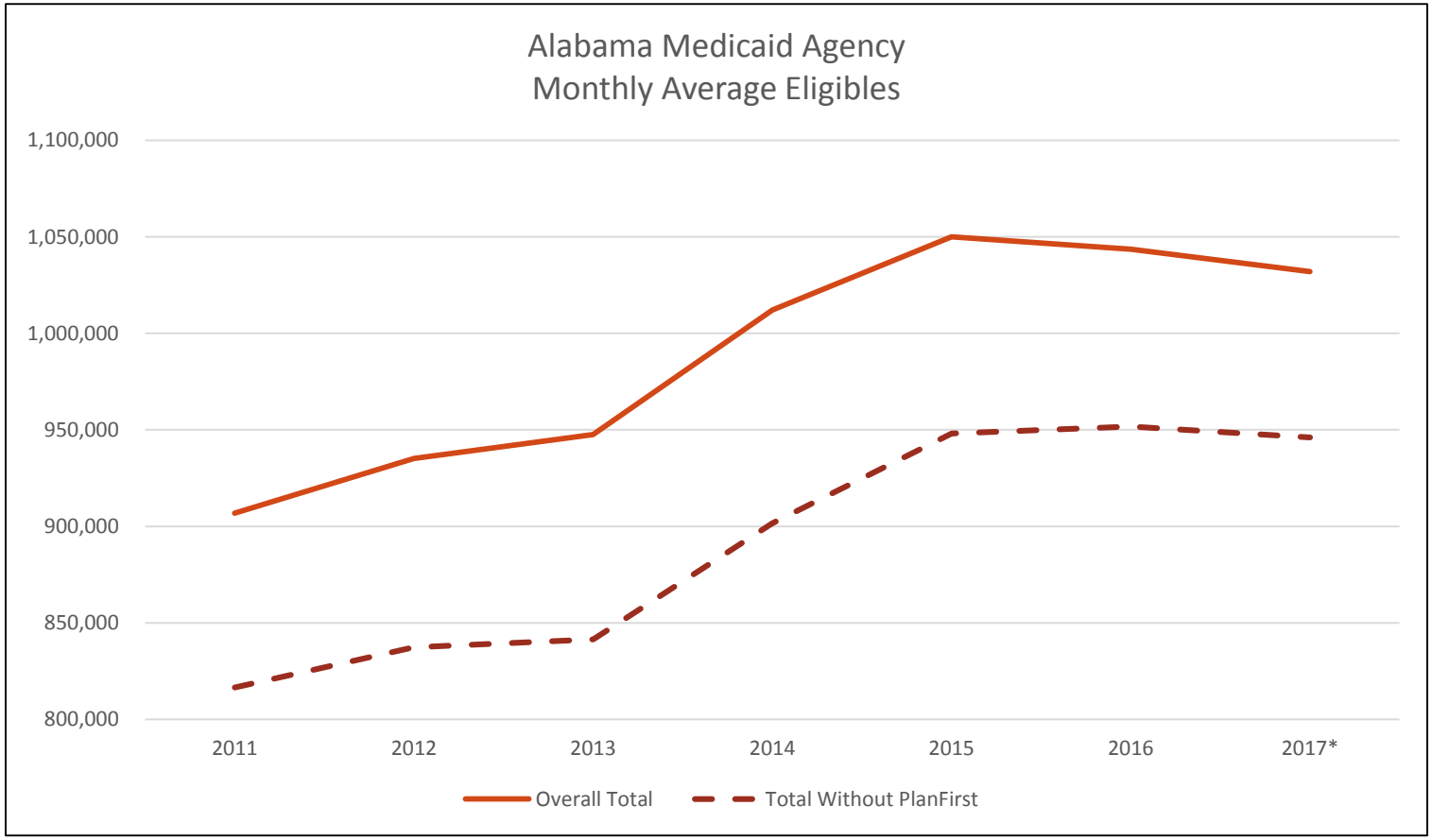
FY 2016 Medicaid Funding Analysis
State and Federal Funding (in millions)



State Funds: $1,942
31%

Federal Funds: $4,388
69%

Monthly Average Eligibles 2011-2017*



* Fiscal Year to date through December 31, 2016

2018 Budget

Alabama Medicaid
2018 State Funding Need

• Total Funding Need	$869 million
• Less BP Fund Allocation	$105 million
• General Fund Request	$764 million

Factors Affecting 2018 Funding Need

- State-mandated and federally-controlled inflationary increases
  - Nursing Homes
  - Pharmacy
  - Medicare Part B Insurance
- FMAP changes – reduces state share requirement for 2018
  - Impact shared with existing state share funding, such as hospitals; other state agencies; and teaching hospitals
- Paybacks
- RCO implementation
- Provider funding

FY 2018 Budget Request Summary		In millions
General Fund 2017		$720
BP funds from 2016 and 2017	65	**$785**
Cash carryover from 2016 operations	29	
Less Federal portion of year end cash	-11	
Net 2017 Funds Used (no carryover to 2018)		**$803**
Increase in General Fund Demand:		
Inflation and utilization increases	42	
One time funding used in 2017	9	
Increase in RCO capitated rates over current spend*	57	
Funding of claims runoff (IBNR)	15	
Other, rounding	2	
Decrease in General Fund Demand:		
Increase in FMAP and reduction in paybacks	-53	
Pharmacy Tax reinstatement	-6	
2018 State Funding Needed	**$66**	**$869**

*The final capitation rates are scheduled to be available in late February 2017.

2018 vs. 2017
(In millions)

	Expenditure Increases	State Share
Normal Operations		
Nursing Homes	$20	$6
Pharmacy	76	16
Medicare Part D Clawback	2	2
Durable Medical Equipment (DME)	5	2
Medicare Part B and other insurance	26	8
Elderly & Disabled waiver slots	10	3
Other “Hospital” costs	7	2
Other – rounding	4	1
Total Benefit Cost	**150**	**40**
Administrative Cost	39	5
Total Cost	**$189**	**$45**
Less Increase in Agency Funding		-3
Net Change in Expenditures		**$42**

Administrative Costs

Administrative costs include multiple components:

- As noted previously, the 2018 budget includes an increase of $39M ($5M state dollars) – substantially all of which relates to major IT projects
- CMS paybacks
- School-Based Services – state share funded by local school boards
- Health Information Technology – over 90% funded by CMS
- Other major multi-year implementation projects: CARES, RCO and ICN
- Normal recurring operating cost – $138M which is less than 2.5% of benefit costs

The General Fund contributes approximately $55M to total administrative cost excluding paybacks

As of December 31, 2016, the Agency had 589 employees (annual salary $28.8M) serving over 1,000,000 enrollees, compared to 2010 when Medicaid had 662 employees and the number of enrollees was 850,000.

Managing Medicaid

- Recovery and Fraud
- Liens
- Other Initiatives

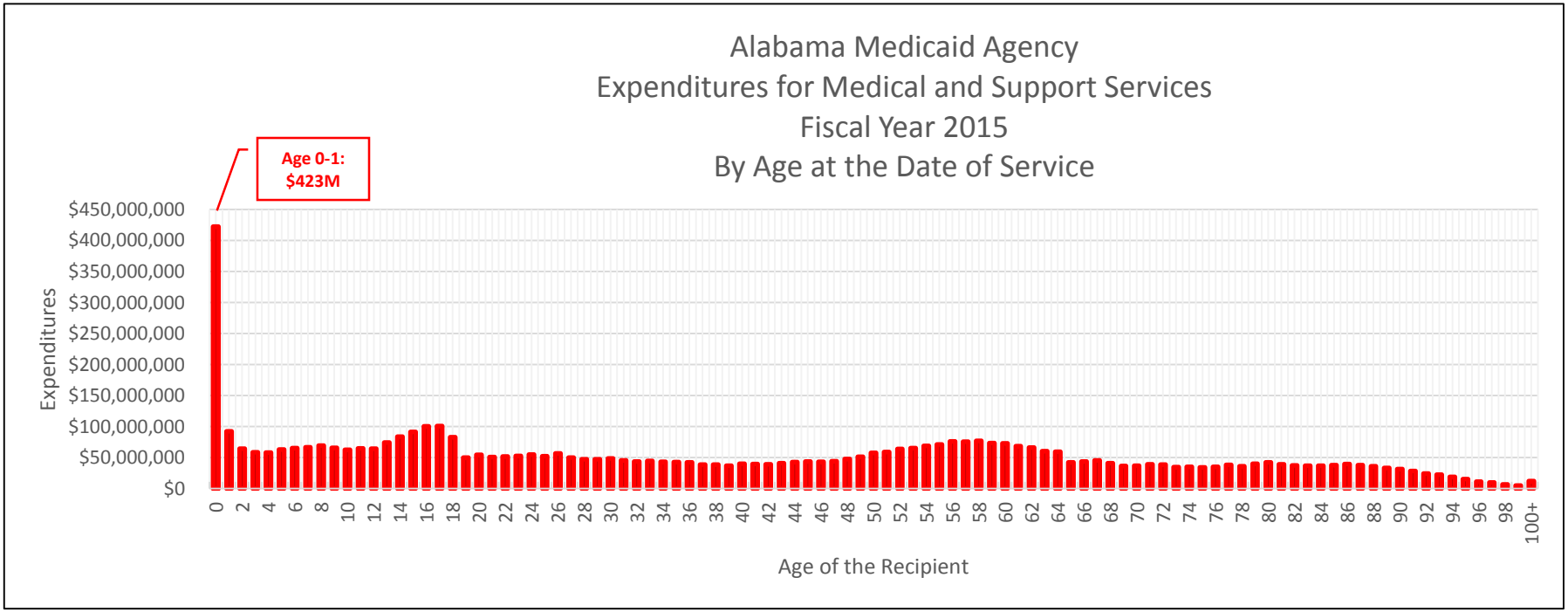
Medicaid Transformation or Status Quo?

Current Quality Outcomes in the Status Quo Environment

- Alabama has the 2nd highest rate of obesity in the nation
- Alabama has the 7th highest rate of heart disease in the nation
- Alabama has a rate of diabetes 50% higher than the national average
- Utilization rates for hospital admissions, inpatient days, and emergency department visits are 13%-17% higher than the national average

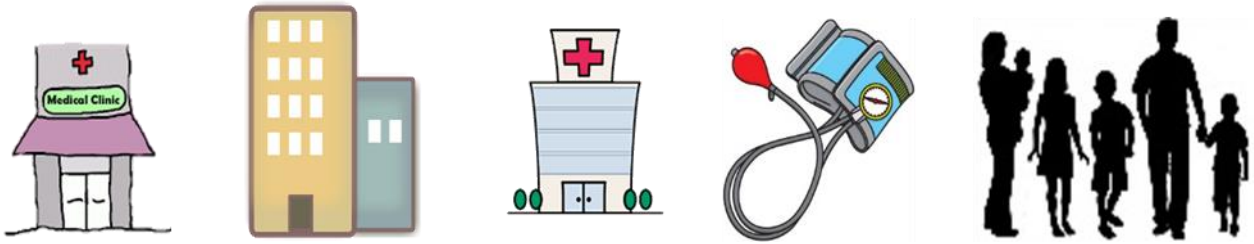
Quality Outcomes in Newborns

- Newborns
  - Infants are significant drivers of Medicaid costs
  - Infant mortality rate: 8.3% (5.8% nationally)
  - High rate of low birth weight infants
  - Low prenatal care rates



Initiative to Transfer Risk Away from the State and Improve Health Outcomes

- RCOs are **provider-led** managed care organizations that will receive an established **per member per month** fee (capitation payment) from the State to **coordinate care and pay providers** for covered services for most Medicaid recipients.
  - Provider-led managed care was a key strategy in achieving 1115 Waiver approval.



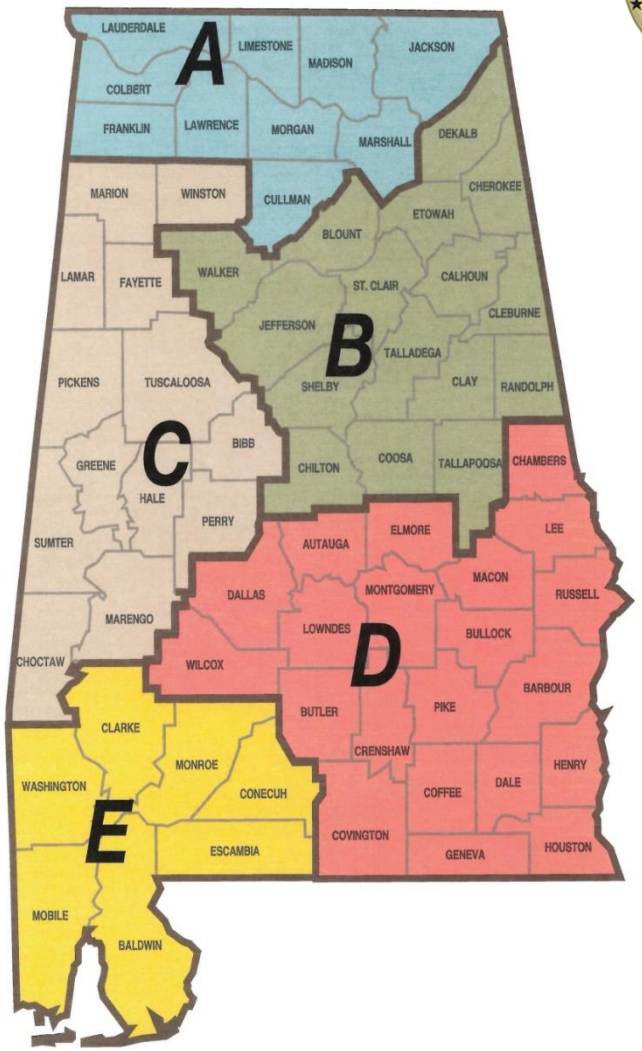
Fully-certified RCOs will be at financial risk which will achieve one of the State's goals in this program.

RCO Incentive Measures

- Improve timeliness of prenatal care
- Reduce incidents of low birth weights
- Improve diabetic testing; early recognition of diabetes
- Increase well child doctor visits
- Improve medication management
- Reduce hospital admissions for conditions that could have been managed in an outpatient setting

RCO Status

- RCOs are moving forward
- Currently there are eight probationary RCOs
- Two probationary RCOs have expressed interest in creating new RCOs in Regions B, D, and E
- RCOs are scheduled to go live October 1 of <u>this</u> year



RCO Implementation Status

CMS has stated that an extension beyond October 1, 2017 will result in the withdrawal of waiver approval.

- Suspension or delay of RCO implementation will result in a return to the status quo of fee for service
- System will continue to reward visits and volume instead of providing patients the right care, at the right place, and at the right time

Failure to implement RCOs means the State – not the RCOs – will continue to bear the full financial risk.

- Significant opportunities to reduce utilization of costly services and improve health outcomes will be lost

The State will lose as much as $748 million in federal (waiver) transformation funds

- The State will lose out on the jobs, taxes, and other economic benefits these funds would have created in the economy
- The State will lose the opportunity to use federal waiver funds for provider-driven projects that improve healthcare quality and efficiency

Potential Provider Projects Funded by Waiver Dollars

- Care diversion from emergency departments to newly-created clinics for mental health recipients
- Improved access to care in rural health:
  - Open new primary care clinics
  - Enhance availability of telemedicine
- New chronic disease prevention and self-management programs for recipients
- Innovative systems to improve healthy birth outcomes

Healthcare Reform

- Repeal of ACA
- Block Grants

Questions